MANAGEMENT OF SUBSTANCE USE DISORDERS IN THE PERINATAL PERIOD

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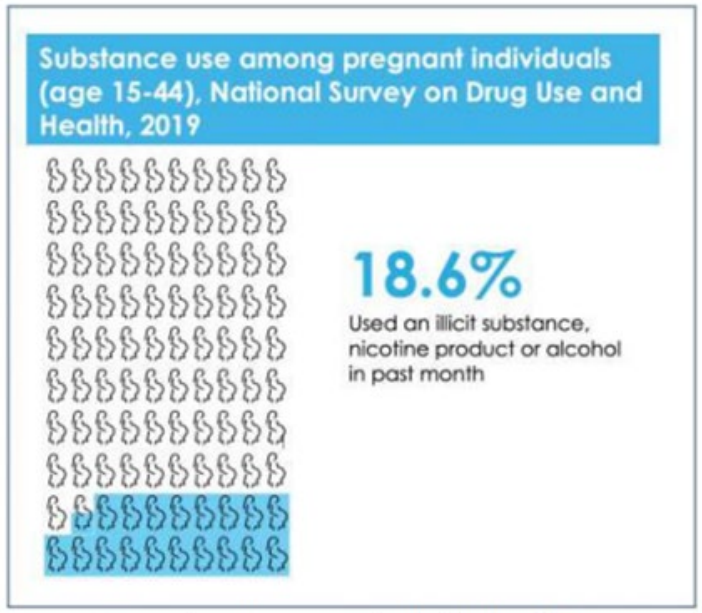
WHY ARE WE TALKING ABOUT THIS?



Proportion of pregnant individuals with past-month substance use, National Survey on Drug Use and Health, 2019.

Smid. Substance Use Disorders Management in Perinatal Period. Obstet Gynecol 2022.

WHY ARE WE TALKING ABOUT THIS?

One in four pregnancy-related deaths is attributed to mental health conditions, including substance use disorder (SUD), making them the leading underlying cause of pregnancy-related deaths, according to data from 2017 to 2019 in 36 states

Trost SL, Beauregard J, Petersen EE, Cox S, Chandra G, St Pierre A, Rodriguez M, Goodman D. Identifying Deaths During and After Pregnancy: New Approaches to a Perennial Challenge. Public Health Rep. 2023 Jul-Aug;138(4):567-572. doi: 10.1177/00333549221110487. Epub 2022 Jul 23. PMID: 35872654; PMCID: PMC10291162.

WHY ARE WE TALKING ABOUT THIS?

Characteristic	No., unweighted	Any postpartum substance use %	Postpartum polysubstance use %
Total	1,920	25.6	5.9

Stewart A, Ko J, Salvesen von Essen B, et al. Association of Mental Health Conditions, Recent Stressful Life Events, and Adverse Childhood Experiences with Postpartum Substance Use — Seven States, 2019–2020. MMWR Morb Mortal Wkly Rep 2023;72:416–420

DARK SIDE OF SUBSTANCE USE DISORDER DIAGNOSIS

- Substance use can be conflated with substance use disorder and stigmatize and equate a person with SUD as “unfit to parent" or “criminal”.
- People who use substances while pregnant are deterred or delayed from seeking care because of fear of detection, prosecution, and punishment.
- Rate of child protection system involvement attributed to perinatal or parental substance use has doubled in recent years.
- Deal with the dilemma of potential risks to a child growing up in a home with ongoing substance use vs impact of family separation
- Child removal can be associated with worsening substance use in the parent and higher rates of PTSD.

Ecker J, Abuhamad A, Hill W, Bailit J, Bateman BT, Berghella V, Blake-Lamb T, Guille C, Landau R, Minkoff H, Prabhu M, Rosenthal E, Terplan M, Wright TE, Yonkers KA. Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. Am J Obstet Gynecol. 2019 Jul;221(1):B5-B28. doi: 10.1016/j.ajog.2019.03.022. Epub 2019 Mar 27. PMID: 30928567.

https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2022/10/12/substance-use-and-substance-use-disorder-among-pregnant-and-postpartum-people

WHAT WILL WE COVER TODAY?

- Screening
- Testing
- Mandated reporting
- Treatment: What does the mother want? Medication assisted withdrawal vs medication assisted treatment with focus on Alcohol use and Opioid use
- Proposed strategies to improve management of substance use disorders in the perinatal period

Non judgmental approach – just like discussing the results of GTT

SHOULD WE SCREEN FOR SUBSTANCE USE IN PREGNANCY AND POSTPARTUM?

- Substance use in pregnancy is common
- Consequences of substance misuse are substantial
- Treatment interventions are available

YES

SCREENING

- Screening should be implemented with every pregnant woman, regardless of whether the provider has suspicions of substance use.
- The American College of Obstetricians and Gynecologists recommends **universal** screening before pregnancy and at the first prenatal visit in partnership with the pregnant individual.
- ACOG also recommends that substance use patterns may change, particularly postpartum; therefore, obgyns should consider screening at least once postpartum.
- The goal of screening is to identify those women with substance use disorders and to help all such women receive treatment if needed. Screening can also help with prevention.

Opioid use and opioid use disorder in pregnancy. Committee Opinion No. 711. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130:e81–94

ARGUMENTS AGAINST [UNIVERSAL] SCREENING

- Validity, reliability and clinical utility of standardized questionnaires in pregnancy is limited.
- Perceptions that patients will be insulted if asked about substance use
- Will patients be truthful especially in the context of legal sanctions and child custody issues?
- Limited time to screen, advise and refer patients

Ecker J, Abuhamad A, Hill W, Bailit J, Bateman BT, Berghella V, Blake-Lamb T, Guille C, Landau R, Minkoff H, Prabhu M, Rosenthal E, Terplan M, Wright TE, Yonkers KA. Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. Am J Obstet Gynecol. 2019 Jul;221(1):B5-B28. doi: 10.1016/j.ajog.2019.03.022. Epub 2019 Mar 27. PMID: 30928567

ARGUMENTS AGAINST UNIVERSAL BIOLOGIC TESTING

- False-negative and false-positive results can occur.
- Poorly timed drug tests, in contrast to questionnaire-based screening, will fail to detect substance use or, conversely, will detect medicinal drugs used during care.
- Biologic testing is limited by substances that are included in a panel.
- Biologic testing is generally costlier than questionnaire based screening.
- In some states the consequences of a false positive result can be quite severe (eg, loss of child custody or jail)

Ecker J, Abuhamad A, Hill W, Bailit J, Bateman BT, Berghella V, Blake-Lamb T, Guille C, Landau R, Minkoff H, Prabhu M, Rosenthal E, Terplan M, Wright TE, Yonkers KA. Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. Am J Obstet Gynecol. 2019 Jul;221(1):B5-B28. doi: 10.1016/j.ajog.2019.03.022. Epub 2019 Mar 27. PMID: 30928567

MANDATED REPORTING

- Mandated reporters who know, or from the infant's symptoms have reasonable cause to suspect, that an infant has any amount of alcohol, a controlled substance, or a metabolite of a controlled substance in the infant's body, **not attributed to medical treatment**, must make a **referral** of suspected child abuse to Centralized Intake.
- Per Child Abuse Prevention and Treatment Act [CAPTA], a **notification** to Centralized Intake is required if the mandated reporter knows that the alcohol, controlled substance, or metabolite, or the child's symptoms are the result of **medical treatment** administered to the infant or the infant's parent. Medical marijuana and Medication Assisted Treatment (MAT) are considered medical treatment. A notification to the department may not be assigned for investigation; however, it will allow for the coordination and implementation of a POSC, as required.

https://www.michigan.gov/mihp/-/media/Project/Websites/mihp/MIHP-Initiatives/MI-Plan-of-Safe-Care-Protocol---Final.pdf?rev=2714cb793dac463698cd1c5a0abef8c2&hash=8DFE29F7FA448EC09B4404A765802DBD

ALCOHOL USE DISORDER

- Jane, is a 24 year old G2P1 female who presents for her first OB appointment at 21 weeks pregnant.
- Unplanned pregnancy. But wanted
- Deferred prenatal care till now because of shame of not being able to quit drinking
- Anxious mainly because she is unable to stop drinking alcohol.

DSM CRITERIA FOR SUBSTANCE USE DISORDER

- There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.
- ? Craving, or a strong desire or urge to use alcohol.
- ?Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
- ?Alcohol use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.
- ? Recurrent alcohol use in situations in which it is physically hazardous.

SUBSTANCE USE HISTORY

- Amount and pattern
  - Alcohol is often taken in larger amounts or over a longer period than was intended
  - A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
  - Tolerance
- Problems related to drinking
  - Recurrent alcohol use resulting in a failure to fulfill major role obligations at work, school, or home.
  - Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol.
  - Important social, occupational, or recreational activities are given up or reduced because of alcohol use.
  - Recurrent alcohol use in situations in which it is physically hazardous.
- Withdrawal
- Use of any other concurrent substances, periods of abstinence and how she was able to maintain abstinence, how she did in prior pregnancy, comorbid psychiatric disorders, family history, support system, history of trauma/abuse and current risk for trauma/abuse
- Check MAPS – MI automated prescription system
- Collateral from PCP or other providers if available

NEXT STEPS

- Physical signs of withdrawal, intoxication use
- Vital Signs
- Physical exam: flushing, diaphoresis, tremor
- Labs: Urine Drug test, CBC, BMP, LFTs
- Child protection reports cannot be made during pregnancy unless concerns are present regarding other children in a woman's care

UDS NEGATIVE FOR OTHER SUBSTANCES PATIENT NOT EXPERIENCING WITHDRAWAL

NONJUDGMENTAL CONVERSATION

- Risk of withdrawal, which can be life threatening and complicate delivery
- Risk of intoxication – violence, injury
- Poor prenatal care
- Fetal alcohol spectrum disorders: Birthweight and length, head circumference, dysmorphic facial features
- Neurodevelopmental delays and CNS deficits
- Fetal/neonatal intoxication and potential for neonatal withdrawal

At-risk drinking and alcohol dependence: obstetric and gynecologic implications. Committee Opinion No. 496. American College of Obstetricians and Gynecologists. Obstet Gynecol 2011;118:383–8

World Health Organization. Guidelines for the identification and management of substance use and substance use disorders in pregnancy. 2014

UDS NEGATIVE FOR OTHER SUBSTANCES PATIENT NOT EXPERIENCING WITHDRAWAL

- Motivational interviewing approach to her substance use
- Recommend follow-up treatment- outpatient vs intensive outpatient vs residential care, ideally in a program tailored to the needs of pregnant and parenting women
- Psychosocial treatments such as peer supports, counseling, or recovery housing should be offered concurrently.
- Address safety planning – counsel on child protective service reporting requirements
- Evaluate for psychiatric comorbidities and counsel on the risk for postpartum emotional complications, for which she is at elevated risk

World Health Organization. Guidelines for the identification and management of substance use and substance use disorders in pregnancy. 2014

UDS NEGATIVE PATIENT NOT EXPERIENCING WITHDRAWAL ASKING ABOUT MAT

- Naltrexone
  - Emerging data for use in pregnancy, few small studies mostly in OUD - no adverse birth outcomes
  - Low relative infant dose (<1%) was observed in a single case report of naltrexone exposure in a 6-week-old breastfed infant.
  - FDA labeling discourages use of both the injectable and oral form of naltrexone in lactating women.
  - Limited data indicate that naltrexone is minimally excreted into breastmilk. If the mother requires naltrexone, it is not a reason to discontinue breastfeeding

  [Lactmed]
- Disulfiram (Antabuse) - not recommended for use in pregnancy due to data re: fetal malformation and risk of severe reaction with ETOH use
- Acamprosate (Campral) - no human pregnancy data.

World Health Organization. Guidelines for the identification and management of substance use and substance use disorders in pregnancy. 2014

UDS NEGATIVE, PATIENT IS EXPERIENCING ALCOHOL WITHDRAWAL

- Data from National Pregnancy Registry for Psychiatric Medications (NPRPM) used to examine the risk of major malformations after first-trimester exposure to benzodiazepines.
- From this registry, a total of 1053 women were eligible for this analysis, including a total of 151 women who had taken a benzodiazepine during the first trimester of pregnancy and a comparison group of 902 women who did not use benzodiazepines.
- Of 151 participants exposed to benzodiazepines during the first trimester, 74 were exposed to clonazepam (49%), 55 were exposed to lorazepam (36.4%), 25 were exposed to alprazolam (16.6%), 4 were exposed to diazepam (2.6%), and 3 were exposed to temazepam (2.0%). Ten participants (6.6%) were exposed to two benzodiazepines during the first trimester. More than half of the women were exposed to benzodiazepines for all three trimesters (n = 79, 55.6%).
- There was no difference in risk of major malformations between the two groups. There were five major malformations in the exposure group (3.21%) and 32 in the comparison group (3.46%; odds ratio 0.92, 95% confidence interval 0.35-2.41).
- Data from this ongoing pregnancy registry offers reassurance that benzodiazepines do not appear to have major teratogenic effects.
- Benzodiazepines can be used for management of withdrawal.

Szpunar MJ, Freeman MP, Kobylski LA, Caplin PS, Gaccione P, Viguera AC, Chitayat D, Hernández-Díaz S, Cohen LS. Risk of major malformations in infants after first-trimester exposure to benzodiazepines: Results from the Massachusetts General Hospital National Pregnancy Registry for Psychiatric Medications. Depress Anxiety. 2022 Dec;39(12):751-759. doi: 10.1002/da.23280. Epub 2022 Jul 31. PMID: 35909254.

NOT IN WITHDRAWAL, UDS POSITIVE FOR OPIATES

- Illicit substances vs prescribed
- Pain management vs MAT for opiate use disorder

Medically supervised withdrawal/detox is not recommended for OUD in pregnancy due to the risk of relapse to opioid use as well as theoretical concerns about the risks associated with withdrawal symptoms

- Illicit substances
  - Non judgmental conversation
  - MAT
- Risks vs benefits discussion

RISK VS BENEFITS - NOWS

- Neonates exposed to methadone or buprenorphine during pregnancy are at risk for neonatal opioid withdrawal syndrome (NOWS) but have improved outcomes compared to infants exposed to untreated OUD
- NOWS is a constellation of withdrawal signs in the neonate including central nervous system dysfunction (e.g., seizures, exaggerated moro reflex, increased muscle tone, irritability), gastrointestinal dysfunction (e.g., vomiting, diarrhea, poor weight gain/feeding), and respiratory dysfunction.
- NOWS can be managed with both pharmacologic (medications such as morphine) and nonpharmacologic interventions (calm, quiet environment, skin to skin contact, breastfeeding, etc.)
- Opioid exposed newborns generally need to be monitored for at least 4-5 days after birth for the development of NOWS
- Requirements for pharmacologic treatment vary from 10% to greater than 50% of opioid exposed newborns

Turner S, Allen VM, Carson G, Graves L, Tanguay R, Green CR, Cook JL. Guideline No. 443b: Opioid Use Throughout Women's Lifespan: Opioid Use in Pregnancy and Breastfeeding. J Obstet Gynaecol Can. 2023 Nov;45(11):102144. doi: 10.1016/j.jogc.2023.05.012. PMID: 37977721.

RISK VS BENEFITS

- Pregnant women who use illicit opioids are at increased risk of sexually transmitted infections, being victims of and/or participating in violence and other illegal activity, concurrent mental health disorders, polysubstance use, poor nutrition, and reliance on social assistance
- Prenatal opioid exposure has been associated with preterm birth, an infant small for gestational age, and decreased fetal heart rate
- Weigh the likelihood of increased pain when reducing or stopping medication against potential adverse effects on the pregnancy from continuing therapeutic doses of pain medication
- Delivery should take place in a center that can provide monitoring for neonatal withdrawal and infants exposed to opiates during pregnancy should be observed carefully during the neonatal period

Turner S, Allen VM, Carson G, Graves L, Tanguay R, Green CR, Cook JL. Guideline No. 443b: Opioid Use Throughout Women's Lifespan: Opioid Use in Pregnancy and Breastfeeding. J Obstet Gynaecol Can. 2023 Nov;45(11):102144. doi: 10.1016/j.jogc.2023.05.012. PMID: 37977721.

MAT FOR OPIATES

- Health care providers can safely recommend buprenorphine/naloxone and Methadone in pregnancy based on current data. Consequently, switching patients to a buprenorphine-only product is not necessary
- Obstetrical care providers should consider dose increases and split doses of methadone or buprenorphine for opioid use disorder to prevent withdrawal and relapse during pregnancy because of the physiological and metabolic changes during pregnancy.
- Health care providers should recommend against using non-prescribed opioids, illicit opioids, or other non-prescribed substances while breastfeeding but women receiving stable doses of opioid agonist therapy or opioids for chronic pain should be supported to breastfeed

Turner S, Allen VM, Carson G, Graves L, Tanguay R, Green CR, Cook JL. Guideline No. 443b: Opioid Use Throughout Women's Lifespan: Opioid Use in Pregnancy and Breastfeeding. J Obstet Gynaecol Can. 2023 Nov;45(11):102144. doi: 10.1016/j.jogc.2023.05.012. PMID: 37977721.

PAIN MANAGEMENT

- Optimize non pharmacological options: Mindfulness, meditation Cognitive Behavioral Therapy (CBT) and other behavioral therapy Physical therapy/Light exercise Biofeedback
- Optimize non opioid options - Acetaminophen NSAIDs (e.g., ibuprofen, ketorolac) Ketamine if available Neuraxial or regional blocks
- Medications used for treatment of OUD are not sufficient alone for pain control.
- Opioids can be safely used for pain control in labor for women on opioid agonist therapy; however, higher doses may be required in these women compared to women who are opioid-naïve
- Health care providers should recommend epidural analgesia early in labor for women with opioid use disorder to avoid hyperalgesia

Turner S, Allen VM, Carson G, Graves L, Tanguay R, Green CR, Cook JL. Guideline No. 443b: Opioid Use Throughout Women's Lifespan: Opioid Use in Pregnancy and Breastfeeding. J Obstet Gynaecol Can. 2023 Nov;45(11):102144. doi: 10.1016/j.jogc.2023.05.012. PMID: 37977721.

MCPAP for moms

DETOXIFICATION FROM OPIOIDS

- Detoxification can be undertaken at any stage in pregnancy, but at no stage should antagonists (such as naloxone, or naltrexone – in the case of opioid withdrawal) be used to accelerate the detoxification process.
- Pregnant women dependent on opioids should be encouraged to use opioid maintenance treatment whenever available rather than to attempt opioid detoxification.

World Health Organization. Guidelines for the identification and management of substance use and substance use disorders in pregnancy. 2014

SMOKING CESSATION

- 50% of women smokers stop smoking during pregnancy
- 13% of women in the United States continue to smoke while pregnant
- About half of the women who manage to stop smoking during pregnancy relapse during the postpartum period
- Smoking is associated with multiple OB and neonatal complications.
- Maternal smoking is also implicated in approximately 23% to 34% of all cases of sudden infant death syndrome (SIDS) and 5% to 7% of preterm-related infant deaths. In addition, children born to mothers who smoke during pregnancy are at increased risk for asthma, colic, and childhood obesity
- Nicotine and other chemicals from the tobacco are transferred into the breast milk at relatively high levels.
- The amount of nicotine transferred into the breast milk is more than double the quantity transferred through the placenta during pregnancy.
- Studies indicate that smoking more than 10 cigarettes per day decreases milk production and alters milk composition.
- Breastfed babies whose mothers smoke more than 5 cigarettes daily exhibit behaviors (e.g. colic and crying) that, in addition to low milk supply, may promote early weaning.

https://womensmentalhealth.org/posts/update-smoking-pregnancy-postpartum-period

POSTPARTUM

- The postpartum period is a high-risk time for relapse and overdose as well as loss to follow-up. Providers should ensure close follow-up in the postpartum period.
- In many states, Medicaid insurance will terminate during the postpartum period rendering women without additional insurance unable to access ongoing SUD treatment.

- *Optimizing postpartum care. ACOG Committee Opinion No. 736. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;131:e140–50.*

PROPOSED STRATEGIES

- Build a Diverse and Culturally Competent Perinatal Behavioral Health Workforce
- Invest in care coordination, peer support, and doula care to expand the perinatal behavioral health workforce.
- Additionally, women can benefit from behavioral health referrals, services for addressing social determinants of health (eg, housing or food insecurity), and connection with peer and community supports.
- More coordination of Perinatal and Behavioral Health Care Services – Collaborative care or One stop shop [Integrated care models]

Ecker J, Abuhamad A, Hill W, Bailit J, Bateman BT, Berghella V, Blake-Lamb T, Guille C, Landau R, Minkoff H, Prabhu M, Rosenthal E, Terplan M, Wright TE, Yonkers KA. Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. Am J Obstet Gynecol. 2019 Jul;221(1):B5-B28. doi: 10.1016/j.ajog.2019.03.022. Epub 2019 Mar 27. PMID: 30928567.

TAKE AWAYS

- Universal Screening
- Non judgmental approach
- Testing only with consent
- Referrals to community connections
- Medication assisted treatment when possible
- Good evidence for MAT for Opioids both in pregnancy and lactation
- Do not forget Nicotine use
- The postpartum period is a high-risk time for relapse and overdose as well as loss to follow-up. Providers should ensure close follow-up in the postpartum period

OTHER RESOURCES

- *National Curriculum for Reproductive Psychiatry*
- *MGH Women's Mental Health*
- *Lactmed*
- *MCPAP for moms*

THANK YOU